FOR OHF USE

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044602

Facility Name: OAK PARK HEALTHCARE CENTER

Address: 625 N HARLEM (Number) OAK PARK (City) 60302 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4303161

Date of Initial License for Current Owners: 11/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	176	64,416	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,248	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,664	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	47,777	1,697	2,866	52,340	8
9	SNF/PED					9
10	ICF	7,601	270		7,871	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,378	1,967	2,866	60,211	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.64%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2866

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	192,146	22,959	7,886	222,991		222,991	4,961	227,952			1
2	Food Purchase		227,396		227,396	(13,113)	214,283	(762)	213,521			2
3	Housekeeping	123,283	31,959	0	155,242		155,242	0	155,242			3
4	Laundry	69,796	23,921	0	93,717		93,717	0	93,717			4
5	Heat and Other Utilities			121,267	121,267		121,267	496	121,763			5
6	Maintenance	67,038	46,428	24,731	138,197		138,197	12,537	150,734			6
7	Other (specify):*			14,783	14,783		14,783	0	14,783			7
8	TOTAL General Services	452,263	352,663	168,667	973,593	(13,113)	960,480	17,232	977,712			8
	B. Health Care and Programs											
9	Medical Director			3,500	3,500		3,500	0	3,500			9
10	Nursing and Medical Records	1,899,068	106,645	8,044	2,013,757		2,013,757	28,704	2,042,461			10
10a	Therapy	101,046	5,207	35,910	142,163		142,163	(2,876)	139,287			10a
11	Activities	65,836	6,356	1,888	74,080		74,080	0	74,080			11
12	Social Services	114,232		4,699	118,931		118,931	0	118,931			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			615	615		615	0	615			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	2,180,182	118,208	54,656	2,353,046		2,353,046	25,828	2,378,874			16
	C. General Administration											
17	Administrative	111,072		220,000	331,072		331,072	(159,995)	171,077			17
18	Directors Fees			0				0				18
19	Professional Services			197,822	197,822		197,822	(153,334)	44,488			19
20	Dues, Fees, Subscriptions & Promotions			34,605	34,605		34,605	(4,070)	30,535			20
21	Clerical & General Office Expenses	87,986	13,326	129,222	230,534		230,534	(24,859)	205,675			21
22	Employee Benefits & Payroll Taxes			431,704	431,704	13,113	444,817	0	444,817			22
23	Inservice Training & Education			2,545	2,545		2,545	1,165	3,710			23
24	Travel and Seminar			0				129	129			24
25	Other Admin. Staff Transportation			444	444		444	1,470	1,914			25
26	Insurance-Prop.Liab.Malpractice			66,583	66,583		66,583	4,372	70,955			26
27	Other (specify):*			0				30,433	30,433			27
28	TOTAL General Administration	199,058	13,326	1,082,925	1,295,309	13,113	1,308,422	(304,689)	1,003,733			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,831,503	484,197	1,306,248	4,621,948		4,621,948	(261,629)	4,360,319			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			22,173	22,173		22,173	(108)	22,065			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			129,654	129,654		129,654	1,085	130,739			32
33	Real Estate Taxes			286,203	286,203		286,203	0	286,203			33
34	Rent-Facility & Grounds			1,081,536	1,081,536		1,081,536	6,612	1,088,148			34
35	Rent-Equipment & Vehicles			32,591	32,591		32,591	(1,475)	31,116			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,552,157	1,552,157		1,552,157	6,114	1,558,271			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		82,407	61,645	144,052		144,052	(17,248)	126,804			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			111,996	111,996		111,996	0	111,996			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		82,407	173,641	256,048		256,048	(17,248)	238,800			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,831,503	566,604	3,032,046	6,430,153	0	6,430,153	(272,763)	6,157,390			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,937)	30		9
10	Interest and Other Investment Income	(1)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(762)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties	(4,324)	21		18
19	Entertainment				19
20	Contributions	(159)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,977)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,146)	20		28
29	Other-Attach Schedule DEFERRED MAINTENANCE XIX-H	(1,725)	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (23,231)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(249,532)		34
35	Other- Attach Schedule	0		35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (249,532)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (272,763)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **OAK PARK HEALTHCARE CENTER**

ID# **1500400**

Report Period Beginning: **01/1/2006**

Ending: **12/31/2006**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference		Sch V	Adj. Summary
	The information listed in B13 thru G65 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0	
2	**Other Care for Outpatients**	0	0	**Line 2**	(36)	
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0	
4	**Non-Patient Meals**	0	0	**Line 4**	0	
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0	
6	**Rented Facility Space**	0	0	**Line 6**	(1,116)	
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0	
8	**Laundry for Non-Patients**	0	0	**Line 8**	(9,48)	
9	**Non-Nsing/Educ Depreciation**	(10,957)	10	**Line 9**	0	
10	**Interest and Other Investment Income**	(1)	32	**Line 10**	0	
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 11a**	0	
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0	
13	**Sales Tax**	(762)	2	**Line 12**	0	
14	**Non-Care Related Interest**	0	0	**Line 12**	0	
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0	
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0	
17	**Non-Care Related Fees**	(200)	20	**Line 16**	0	
18	**Fines and Penalties**	(4,324)	21	**Line 17**	0	
19	**Entertainment**	0	0	**Line 18**	0	
20	**Contributions**	(159)	20	**Line 19**	0	
21	**Owner or Key Man Insurance**	0	0	**Line 20**	(2,40)	
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	(8,82)	
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0	
24	**Bad Debt**	0	0	**Line 23**	0	
25	**Fund Raising, Advertising and Promotional**	(3,977)	20	**Line 24**	0	
26	**Income & Ut. Personal Property Replacement Taxes**	0	0	**Line 25**	0	
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0	
28	**Yellow Page Advertising**	(1,146)	20	**Line 27**	0	
29	**Non-Paid Workers**	0	0	**Line 28**	0	
30	**Donated Goods**	0	0	**Line 29**	(12,81)	
31	**Amortization Expense**	0	0	**Line 30**	(10,01)	
32	PG 5 LINE 29 - DEFERRED MAINTENANCE XIX-H	(1,720)	6	**Line 31**	0	
33				**Line 32**	0	
34				**Line 33**	0	
35				**Line 34**	0	
36				**Line 35**	0	
37				**Line 36**	0	
38				**Line 37**	(10,01)	
39				**Line 38**	0	
40				**Line 39**	0	
41				**Line 40**	0	
42				**Line 41**	0	
43				**Line 42**	0	
44				**Line 43**	0	
45				**Line 44**	0	
46				**Line 45**	(93,31)	

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	4,961	0	0	0	0	0	0	0	0	0	4,961	1
2	Food Purchase	(762)	0	0	0	0	0	0	0	0	0	0	(762)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	496	0	0	0	0	0	0	0	0	0	496	5
6	Maintenance	(1,725)	14,262	0	0	0	0	0	0	0	0	0	12,537	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,487)	19,719	0	0	0	0	0	0	0	0	0	17,232	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	28,704	0	0	0	0	0	0	0	0	0	28,704	10
10a	Therapy	0	7,674	(10,550)	0	0	0	0	0	0	0	0	(2,876)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	36,378	(10,550)	0	0	0	0	0	0	0	0	25,828	16
	C. General Administration													
17	Administrative	0	(159,995)	0	0	0	0	0	0	0	0	0	(159,995)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(153,334)	0	0	0	0	0	0	0	0	0	(153,334)	19
20	Fees, Subscriptions & Promotions	(5,482)	0	1,412	0	0	0	0	0	0	0	0	(4,070)	20
21	Clerical & General Office Expenses	(4,324)	(89,760)	69,225	0	0	0	0	0	0	0	0	(24,859)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,165	0	0	0	0	0	0	0	0	1,165	23
24	Travel and Seminar	0	0	129	0	0	0	0	0	0	0	0	129	24
25	Other Admin. Staff Transportation	0	0	1,470	0	0	0	0	0	0	0	0	1,470	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,372	0	0	0	0	0	0	0	0	4,372	26
27	Other (specify):*	0	0	30,433	0	0	0	0	0	0	0	0	30,433	27
28	**TOTAL General Administration**	(9,806)	(403,089)	108,206	0	0	0	0	0	0	0	0	(304,689)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,293)	(346,992)	97,656	0	0	0	0	0	0	0	0	(261,629)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,937)	0	10,829	0	0	0	0	0	0	0	0	(108)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1)	0	1,086	0	0	0	0	0	0	0	0	1,085	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,612	0	0	0	0	0	0	0	0	6,612	34
35	Rent-Equipment & Vehicles	0	0	(1,475)	0	0	0	0	0	0	0	0	(1,475)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,938)	0	17,052	0	0	0	0	0	0	0	0	6,114	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(17,248)	0	0	0	0	0	0	0	0	(17,248)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(17,248)	0	0	0	0	0	0	0	0	(17,248)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,231)	(346,992)	97,460	0	0	0	0	0	0	0	0	(272,763)	45

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: OAK PARK HEALTHCARE CENTE — # 0040402 — Report Period Beginning: 01/01/2000 — Ending: 12/31/2000

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization — Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 6)		Sum. 6
1	V	17 MANAGEMENT FEES	228,000	CAREPLUS MGMT INC		$	$ (228,000)	1	-228000
2	V	19 ADMIN. CONSULTANT FEE	148,500				(148,500)	2	-148500
3	V	19 DATA PROCESSING FEES	8,800				(8,800)	3	-8800
4	V	22 CLERICAL FEES	89,760				(89,760)	4	-89760
5	V	1 DIETARY CONSULTANT FEE	5,500				(5,500)	5	-5500
6	V	2 DIETARY SALARIE				10,461	10,461	6	10461
7	V	5 ELECTRICITY				496	496	7	496
8	V	6 REPAIRS				876	876	8	876
9	V	8 MAINTENANCE SALARIE				13,386	13,386	9	13386
10	V	10 NURSING				28,704	28,704	10	28704
11	V	20a THERAPY SALARIE				7,674	7,674	11	7674
12	V	21 ACTIVITIES SALARIE				68,085	68,085	12	68085
13	V	23 PROFESSIONAL FEES				3,966	3,966	13	3966
14	total		472,560			125,568	$ * (346,992)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 1,412	$ 1,412	15	1412
16	V	21	OFFICE SALARIES/EXPENSES		" "		69,225	69,225	16	69225
17	V	23	SEMINARS		" "		1,165	1,165	17	1165
18	V	24	TRAVEL		" "		129	129	18	129
19	V	25	TRANSPORTATION		" "		1,470	1,470	19	1470
20	V	26	INSURANCE		" "		4,372	4,372	20	4372
21	V	27	EMPLOYEE BENEFITS		" "		30,433	30,433	21	30433
22	V	30	SL DEPRECIATION		" "		10,829	10,829	22	10829
23	V	32	INTEREST		" "		1,086	1,086	23	1086
24	V	34	OFFICE RENT		" "		6,612	6,612	24	6612
25	V	35	EQUIP RENT/AUTO LEASE	9,728	" "		8,253	(1,475)	25	-1475
26	V								26	
27	V								27	
28	V								28	
29	V	10a	THERAPY SERVICES	35,910	CAREPLUS REHABILITATIVE SERVICES		25,360	(10,550)	29	-10550
30	V	39	ANCILLARY THERAPY	58,706	" "		41,458	(17,248)	30	-17248
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 104,344			$ 201,804	$ * 97,460	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCI	50.00	SEE ATTACHED	5.6	9.28	SALARY	17,162	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	5.6	9.28	" "	17,162	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 34,324		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	60,174	$ 10,461	1
2	5	ELECTRICITY	" "	648,651	14	5,352		60,174	496	2
3	6	REPAIRS	" "	648,651	14	9,448		60,174	876	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	60,174	13,386	4
5	10	NURSING	" "	648,651	14	309,417	309,417	60,174	28,704	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	60,174	7,674	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	60,174	60,005	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		60,174	3,966	8
9	20	DUES/LICENSES/WANT ADS	" "	648,651	14	15,220		60,174	1,412	9
10	21	OFFICE SALARIES/EXPENSES	" "	648,651	14	746,225	559,379	60,174	69,225	10
11	23	SEMINARS	" "	648,651	14	12,554		60,174	1,165	11
12	24	TRAVEL	" "	648,651	14	1,390		60,174	129	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		60,174	1,470	13
14	26	INSURANCE	" "	648,651	14	47,123		60,174	4,372	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		60,174	30,433	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		60,174	10,829	16
17	32	INTEREST	" "	648,651	14	11,707		60,174	1,086	17
18	34	OFFICE RENT	" "	648,651	14	71,276		60,174	6,612	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		60,174	8,253	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 260,554	25

Print Preview

Print Page 8A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

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STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 1,086	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	04/95	1,925,000	439,500		PRIME+	48,149	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							361	7
8	MEMBERS' LOANS PAYABI	X		WORKING CAPITAL		11/1/99	750,000	750,000			81,144	8
9	TOTAL Facility Related						$ 2,675,000	$ 1,189,500			$ 130,740	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,675,000	$ 1,189,500			$ 130,740	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	50,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,733	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,267)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	288,470	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	286,203	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	272,713	8
	1996	281,916	9
	1997	286,264	10
	1998	292,508	11
	1999	285,617	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO 2 MONTHS OF THE 1999 TAX YEAR ALLOCATED FROM LESSOR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,926 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2+BASEMENT/ 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	22,950		$	1
2					2
3	TOTALS	22,950		$	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR			1999	74,653	1,914	39	1,914		2,009	9
10	WINDOWS / FENCE / CEILING			2000	13,360	466	27.5	466		466	10
11	WINDOWS / SIGNS / FLOORING / WALLPAPER			2000	43,229	1,347	27.5	1,347		1,347	11
12	WINDOWS /FLOORING /WALLPAPER / NURSE STATION			2000	29,709	765	27.5	765		765	12
13	FLOORING / DOORS /WALLS /HVAC SYSTEM			2000	56,310	1,280	27.5	1,280		1,280	13
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING			2000	30,160	554	27.5	554		554	14
15	WINDOWS / PLUMBING / PAINTING & DECORATING			2000	41,459	388	27.5	388		388	15
16	WINDOW TREATMENTS			2000	19,213	2,746	15	640	(2,106)	640	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					98		98			34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 9,558		$ 7,452	$ (2,106)	$ 7,449	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$		$	37
38	Current Year Purchases	106,944	12,713	3,882	(8,831)	8-15 YRS		38
39	Fully Depreciated Assets							39
40	** RELATED PARTY - ALLOCATED SL DEPN: CAREPLUS MGMT, 10,731		10,731	10,731				40
41	TOTALS	$ 106,944	$ 23,444	$ 14,613	$ (8,831)		$	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 33,002	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 22,065	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (10,937)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 7,449	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FAIRMOUNT OF OAK PARK LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		204	11/01/99	$ 1,081,536			3
4	Additions							4
5								5
6								6
7	TOTAL		204		$ 1,081,536 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/99
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$
13.	12/31/2002	$
14.	12/31/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 32,591 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 13,217	$		$ 13,217	1
2	Licensed Speech and Language Development Therapist		hrs			3,267			3,267	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			42,223			42,223	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			2,938			2,938	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				59,984		59,984	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					6,086		6,086	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					16,337		16,337	13
14	TOTAL			$		$ 61,645	$ 82,407		$ 144,052	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,442,125		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,160		6
7	Other Prepaid Expenses	148,115		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	291,628		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,911,028	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	288,880		15
16	Equipment, at Historical Cost	121,909		16
17	Accumulated Depreciation (book methods)	(22,268)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 388,521	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,299,549	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 337,024	$	26
27	Officer's Accounts Payable	750,000		27
28	Accounts Payable-Patient Deposits	20,603		28
29	Short-Term Notes Payable	1,315,000		29
30	Accrued Salaries Payable	60,533		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,992		31
32	Accrued Real Estate Taxes(Sch.IX-B)	288,470		32
33	Accrued Interest Payable	11,446		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,790,068	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,790,068	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (490,519)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,299,549	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (106,456)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (106,456)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(384,063)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (384,063)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (490,519)	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,046,089	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,046,089	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,046,090	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 973,593	31
32	Health Care	2,353,046	32
33	General Administration	1,295,309	33
	B. Capital Expense		
34	Ownership	1,552,157	34
	C. Ancillary Expense		
35	Special Cost Centers	144,052	35
36	Provider Participation Fee	111,996	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,430,153	40
41	**Income before Income Taxes (line 30 minus line 40)****	(384,063)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (384,063)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN IS PREPARED ON CASH BASIS.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,309	2,585	$ 62,355	$ 24.12	1
2	Assistant Director of Nursing	2,116	2,486	52,459	21.10	2
3	Registered Nurses	24,171	25,684	537,251	20.92	3
4	Licensed Practical Nurses	26,050	27,288	445,442	16.32	4
5	Nurse Aides & Orderlies	83,268	89,705	764,225	8.52	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,608	9,437	101,046	10.71	8
9	Activity Director					9
10	Activity Assistants	10,179	10,911	65,836	6.03	10
11	Social Service Workers	6,047	6,632	114,232	17.22	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,208	30,760	13.93	13
14	Head Cook	4,360	4,651	64,777	13.93	14
15	Cook Helpers/Assistants	14,457	15,464	96,609	6.25	15
16	Dishwashers					16
17	Maintenance Workers	3,686	3,878	67,038	17.29	17
18	Housekeepers	19,843	21,071	123,283	5.85	18
19	Laundry	10,927	11,547	69,796	6.04	19
20	Administrator	2,636	2,637	72,735	27.58	20
21	Assistant Administrator	1,655	1,667	38,337	23.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,921	8,454	87,986	10.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,960	2,123	37,336	17.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	232,217	248,428	$ 2,831,503 *	$ 11.40	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,781	1-3	35
36	Medical Director	O	3,500	9-3	36
37	Medical Records Consultant	N	3,360	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	3,050	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,888	11-3	44
45	Social Service Consultant	E	4,699	12-3	45
46	Other(specify)	S			46
47			0		47
48					48
49	TOTAL (lines 35 - 48)		$ 37,678		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	52	1,039	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	52	$ 1,039		53

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAM BIBER	ADMIN	0.00%	$ 66,988
SHERRY FICKENSCHER	ADMIN	0.00%	5,747
KEVIN MEALS	ASST ADMIN	0.00%	1,982
BERNADETTE PRUSINKI	ASST ADMIN	0.00%	36,355
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 111,072

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 220,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 220,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 8,800
CAREPLUS MGMT	ADMIN CONSULT	148,500
THRESHHOLD	DATA PROC	490
AMERICAN DATA	DATA PROC	2,400
KBKB	ACCT	28,850
MEYER MAGENCE	LEGAL	1,050
KEANE & KEANE	LEGAL-REAL ESTATE TX	2,500
RICHARD PEELO	M/C COST REPORT	3,750
PERSONNEL PLANNERS	UNEMPL CONSULT	1,482
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 197,822

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,053
Unemployment Compensation Insurance	48,219
FICA Taxes	213,393
Employee Health Insurance	84,711
Employee Meals	13,160
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	35,054
EMPLOYEE BENEFITS-OTHER	3,227
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 444,817

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,084
Health Care Worker Background Check	542
(Indicate # of checks performed 45)	
ADV & PROMO/MARKETING	5,123
DUES & SUBSCRIPTIONS	8,692
LICENSES & PERMITS	3,805
TRUST FEES, CONTRIBUTIONS,etc.	359
MGMT CO ALLOCATION	1,412
LESS TRUST FEES, CONTRIB, etc.	(359)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,977)
Yellow page advertising	(1,146)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,535

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MGMT CO ALLOCATION	129
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 129

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	2000	$ 2,070	3	$	$	$	$ 345	$ 690	$ 690	$ 345	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,070		$	$	$	$ 345	$ 690	$ 690	$ 345	$	$

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE 7,297**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,695** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,996**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,066** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Facility Name & ID Number OAK PARK HEALTHCARE CENTER #0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	6781	
	REPAIRS & MAINTENANCE		1105	
			0	7886
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	HEAT & OTHER UTILITIES			
	GAS HEAT		42541	
	ELECTRICITY		48588	
	WATER		30138	
	CABLE TV - LOBBY		0	
			0	121267
6	MAINTENANCE			
	GROUNDS MAINTENANCE		4775	
	PAINTING & DECORATING		2070	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4088	
	ELEVATOR MAINTENANCE & REPAIR		6209	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3950	
	FIRE SERVICE		3639	
			0	
			0	
			0	24731
7	OTHER			
	SCAVENGER		14371	
	SECURITY SERVICE		412	14783
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	3500	3500

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	1,039	
	LABORATORY & XRAY EXPENSE		595	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	3360	
	PHARMACY CONSULTANT	XVIII B39	3050	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B47	0	
	RN CONSULTANT	XVIII B38	0	
			0	
			0	8044
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	THERAPY CONTRACT SERVICES		21510	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	7200	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	7200	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	35910
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	1888	
			0	1888
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	4699	
			0	4699
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OAK PARK HEALTHCARE CENTER #0044602 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		615	615
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	220000	220000
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	11690	
	ADMINISTRATIVE CONSULTANTS	XIX C	148500	
	PROFESSIONAL FEES	XIX C	37632	
	ACCOUNT COLLECTION FEES		0	197822
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	3977	
	EMPLOYEE WANT ADS	XIX F	16084	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	8692	
	LICENSES & PERMITS	XIX F	3805	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1146	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	200	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	159	
	H/CARE WORKER BACKGROUND CHECK	XIX F	542	34605
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES (INCL OD FEES 4,324)	VI 18	4324	
	EQUIPMENT REPAIR & MAINTENANCE		5934	
	OUTSIDE CLERICAL SERVICES		89760	
	PENALTIES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		356	
	TELEPHONE		28848	
	MESSENGER SERVICE		0	
			0	129222
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	213393	
	UNEMPLOYMENT COMPENSATION	XIX D	48219	
	WORKERS COMPENSATION INSURANCE	XIX D	47053	
	HOSPITALIZATION INSURANCE	XIX D	84711	
	EMPLOYEE BENEFITS - OTHER	XIX D	3227	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRIB	XIX D	35054	
	EMPLOYEE MEALS	XIX D	47	431704
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		2545	2545
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		444	444
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		66583	66583
27	OTHER			
	BAD DEBTS	VI 24	0	
			0	0
	GRAND TOTAL COLUMN 3 OTHER			1306248

Facility Name & ID Number OAK PARK HEALTHCARE CENTER #0044602
EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 COLUMN 3 OTHER LINES 2 AND 22

TOTAL FOOD PURCHASE	227,396	PATIENT MEALS	180633
LESS SALES TAX	-762	ADD EMPLOYEE MEALS	10980
NET FOOD	228158	TOTAL MEALS/YEAR	191613
TOTAL PATIENT CENSUS	60211	NET FOOD	228158
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	191613
TOTAL PATIENT MEALS	180633	COST PER MEAL	1.19
		TIME EMPLOYEE MEALS	10980
ADD # EMPLOYEE MEALS/DAY	30		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	13066
TOTAL EMPLOYEE MEALS	10980		